

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Castanaga, Imelda (ARCH/Expanded ARCH)	CHAPTER 100.1
Address: 94-972 Lumimoe Street, Waipahu, Hawaii 96797	Inspection Date: August 8, 2017 Annual

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (a)(4) No person, group of persons, or entity shall operate an ARCH or expanded ARCH without a license previously obtained under and in compliance with this chapter and chapter 321, HRS.</p> <p>The license issued by the department shall be posted in a conspicuous place visible to the public, on the premises of the ARCH or expanded ARCH;</p> <p><b><u>FINDINGS</u></b> Current license received; however, the license was not visible.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><b><u>FINDINGS</u></b> Substitute care giver (SCG) #1 and #2, no current physical examination (PE). PEs dated 7/28/16. Repeat citation (2016).</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b><u>FINDINGS</u></b> SCG #1 and #2, no annual tuberculosis clearance available.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-12 <u>Emergency care of residents and disaster preparedness.</u> (a)(3)  The licensee shall maintain written procedures to follow in an emergency which shall include provisions for the following:</p> <p>Response to disasters which would include evacuation, emergency shelters, and food supply, and as directed by the Civil Defense.</p> <p><b><u>FINDINGS</u></b>  Emergency supplies for six (6) persons living in the home does not conform to Civil Defense directives. Repeat citation (2016); i.e. one (1) flat of 500 ml water bottles.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	



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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><b><u>FINDINGS</u></b> First aid box contained one (1) tube of “Triple Antibiotic, expired 1/11”.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><b><u>FINDINGS</u></b> Resident #1, Physician order dated <u>09/29/16</u> reads, "Vraylar 1.5 mg one tablet at night". However, no initial indicated in the medication administration record (MAR) until <u>10/01/16</u>.</p>	<p><b>PART 1</b></p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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Licensee's/Administrator's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_